DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE-2493 (Rev. 6-2003)

REFERRAL FOR PRE-ADMISSION CONSULTATION
(Print this form on blue paper)

Before completing this form, read the attached instructions. Referral to a Resource Center for Pre-Admission Consultation (PAC) is required for Nursing Homes, Facilities for the Developmentally Disabled, Adult Family Homes, Community Based Residential Facilities and Residential Care Apartment Complexes by ss. 50.04(2h), 50.033(2s), 50.035(4n) and 50.034(5n), Wis. Stats., respectively. Failure to comply with these provisions may result in the determination of a violation and assessment of a forfeiture. Use of this form, or a similar format providing the same information, for referral to the Resource Center meets the requirements of ss. 50.04(2h), 50.033(2s), 50.035(4n) and 50.034(5n), Wis. Stats. Provision of the referred person's Social Security Number is voluntary. Personally identifiable information on this form will only be used to determine the prospective resident's eligibility for the Family Care benefit.

Distribution: Complete and submit a COPY of this form to the Resource Center. Maintain the ORIGINAL of this form, PRINTED ON BLUE PAPER, in the resident's file upon admission.

PERSON REFERRED

Name - Person Referred (Last, First, Middle)		Date of Birth
Home Address (Street, City, State, and Zip Code)		Social Security Number (voluntary)
Telephone Number	Date of Referral	County of Residence
Type of Placement ☐ Long Term ☐ Short Term ☐ Other (specify)		Anticipated Date of Admission

FACILITY MAKING REFERRAL ☐ **NH** ☐ **FDD** ☐ **AFH** ☐ **CBRF** ☐ **RCAC**

Name - Facility Making Referral	
Street Address, City, State and Zip Code	
Facility Staff Contact Person	Telephone Number

INDICATE BELOW WHERE THE PERSON WHO IS BEING REFERRED, OR A FAMILY MEMBER, CAN BE REACHED IN THE NEXT 5 WORKING DAYS

Name – Temporary or Current Location (if not at permanent residence, specify)	Telephone No. of Current or Temporary Location
Name – Family Contact	Telephone Number – Family Contact

PROVIDE THE FOLLOWING INFORMATION

Name – Person Who Contacted the Facility (if different from the referred person)	
Relationship to Referred Person	Telephone Number
Name – Guardian or Activated Power of Attorney for Health Care	(Check One) ☐ Guardian ☐ Activated POAHC
Street Address, City, State and Zip	Telephone Number
Name - Resource Center	
Address (City, State and Zip)	

(ORIGINAL COPY OF THIS FORM PRINTED ON BLUE PAPER REMAINS AT FACILITY) (WHITE PHOTOCOPY TO RESOURCE CENTER)

DEPARTMENT OF HEALTH AND FAMILY SERVICES STATE OF WISCONSIN
Division of Disability and Elder Services
DDE-2493-I (Rev. 6-2003)

INSTRUCTIONS
DDE-2493
Referral for Pre-Admission Consultation Form

These instructions are formatted to follow the Referral for Pre-Admission Consultation form. Please use these instructions to assist in filling out each line on the form.

Name - Person Referred (Last, First, Middle): This line should contain the complete name (last, first, middle) of the person being referred to the Resource Center.

Date of Birth: This line should contain the date of birth of the person being referred to the Resource Center.

Home Address (Street, City, State and Zip Code): This line should contain the complete address where the person being referred usually lives or resides.

Social Security Number (voluntary): If the facility has access to the SSN and/or the person being referred is willing to provide his/her SSN, it should be entered on this line. The SSN is an important piece of information and should be collected whenever possible. It will be kept confidential.

Telephone Number: This line should contain the telephone number for the permanent residence of the person being referred to the Resource Center.

Date of Referral: This line should contain the date that the facility filled out the referral form and sent it to the Resource Center.

County of Residence: This line should contain the name of the County in which the referred person's permanent residence is located.

Type of Placement: Check the appropriate box to indicate the type of placement.

Anticipated Date of Admission: This line should contain the anticipated date of admission to the facility.

Name - Facility Making Referral: This line should contain the name of the Nursing Home, Facility for the Developmentally Disabled, Adult Family Home, Community Based Residential Facility, or Residential Care Apartment Complex that is making the referral for Pre-Admission Consultation to the Resource Center.

Street Address, City, State and Zip Code: This line should contain the complete address of the facility that is making the referral for Pre-Admission Consultation to the Resource Center.

Facility Staff Contact Person: This line should contain the name of the admissions planner for the facility making the referral.

Telephone Number: This line should contain the telephone number of the contact person at the facility making the referral.

Name - Temporary or Current Location (if not at permanent residence, specify): This line should contain the name of the facility or residence where the person being referred is temporarily staying, if different than permanent residence indicated above.

Telephone Number of Current or Temporary Location: This line should contain the telephone number of the temporary or current location of the person being referred.

Name - Family Contact: This line should contain the name of the family member to contact for the person being referred to the Resource Center.

Telephone Number: This line should contain the telephone number of the family member for the person being referred to the Resource Center.

*****PROVIDE THE FOLLOWING INFORMATION*****

Name - Person Who Contacted the Facility (if different from the referred person): If the person who contacted the facility is someone other than the person being referred to the Resource Center, this line should contain that person's full name.

Relationship to Referred Person: This line should contain the relationship that exists between the person who actually contacted the facility and the person being referred to the Resource Center, i.e., parent, spouse, son, daughter.

Telephone Number: This line should contain the telephone number of the person who contacted the facility, if different from the referred person.

Name - Guardian or <u>Activated</u> Power of Attorney for Health Care: This line should contain the name of the Guardian or Activated Power of Attorney for Health Care (POAHC), if known. If a name is listed, check the appropriate box (Guardian or Activated POAHC) on the same line. An activated POAHC is defined as: an individual's power of attorney for health care takes effect upon a finding of incapacity by 2 physicians, as defined in s.448.01(5), or one physician and one licensed psychologist, as defined in s.455.01(4), who personally examine the principal and sign a statement specifying that the principal has incapacity. Wis. Stats., Chapter 155.05(2).

Street Address, City, State and Zip Code: This line should contain the complete address of the person listed as Guardian or Activated Power of Attorney for the person being referred to the Resource Center.

Telephone Number: This line should contain the telephone number of the person listed as Guardian or Activated Power of Attorney for the person being referred to the Resource Center.

Name - Resource Center: This line should contain the name of the Resource Center to which this referral for Pre-Admission Consultation is being sent.

Address (City, State and Zip Code): This line should contain the address of the Resource Center to which this referral for Pre-Admission Consultation is being sent.
